HUNTINGTON COUNTY DEPARTMENT OF HEALTH

354 N. JEFFERSON ST., SUITE 201
HUNTINGTON, IN 46750
(260) 358-4831 OFFICE
(260) 358-4899 FAX

Fee Waiver REQUEST FORM

Personal information

Guardian Name: _____
Patient or Child name: _____
Address: _____
_____
Home Phone#: _____
Alternate phone/cell#: _____

Information to determine need

Annual Income: $_____
Number of Household dependents: _____
Medicaid ID#_____

For Documentation and Audit purposes

Reason for Request:

_____
_____
_____
_____

I hereby attest that all the information that I have provided is true, accurate, and honest. If any information that I have provided is indeed false, then I understand that this false information may be punishable by law, fines or imprisonment according to the Huntington County Prosecutors Office.

Guardian or patient Signature: _____
Date signed: _____

Debra K Doctor RN (witness) Debra K Doctor RN
Public Health Nurse
Huntington County Health Department

Amount waved: $ _____
(Circle one) For: Lice Products Shot fees other fees_____

PLEASE COPY DLN OR OTHER FORM OF IDENTIFICATION